

Please use your supply of existing older cards prior to use of the new cards.

As a reminder, please:

- Complete *Birth Facility* field
- Identify the *Follow-Up Care* ID# for the baby's outpatient clinic or facility (midwives use "M#")
- If applicable, use check boxes to indicate same ID number(s)
- Newest cards are in royal purple ink

SEE DIRECTIONS ON BACK. PLEASE PRINT.

Demographic Information

Front

Filter Paper

DO NOT USE THIS AREA

WASHINGTON STATE NEWBORN SCREENING

MOTHER'S INFORMATION		CHILD'S INFORMATION	
LAST NAME		Birth: Mo Day Yr Hr : Mn am pm	
FIRST NAME		Collection: / / : : □ □	
Maternal Steroids <input type="checkbox"/> (within 7 days) Date last		Name: First Last	
MISCELLANEOUS INFORMATION			
Sex: M <input type="checkbox"/> F <input type="checkbox"/>			
Birth Order: single <input type="checkbox"/> if multiple A <input type="checkbox"/> B <input type="checkbox"/>			
Birthweight: _____ grams			
OR _____ lbs. _____ oz.			
Race/Ethnicity: (Check all that apply)			
White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> NaAm <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/>			
BIRTH FACILITY		CHILD'S SPECIAL CONSIDERATIONS	
Facility ID (born at): - - - - -		NICU <input type="checkbox"/> HA/TPN <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/>	
Name of Facility: _____ (For home-birth, use birth attendant ID)		(within 24 hours) (within 7 days) (within 24 hours)	
SUBMITTER ID		FOLLOW-UP CARE	
Collected at (facility):		Follow-Up Clinic ID:	
<input type="checkbox"/> Same as Birth Facility		<input type="checkbox"/> Same as Submitter	
<input type="checkbox"/> REFUSED: Check box if refused and sign form on reverse (required)			

Barcode number

903™

XXXXXX/XXXX

LOT

34800001

SN

34800001

SATURATE EACH CIRCLE COMPLETELY BEFORE MOVING TO THE NEXT

Back

Refusal of Testing

Newborn screening to detect serious congenital disorders is mandatory in the state of Washington. Parents or guardians may refuse testing only on the basis of religious practices or tenets as provided by RCW 70.83.020.

I am the parent or guardian of the infant named below. I have been counseled on the importance of Newborn Screening tests and I have received literature on Newborn Screening. My questions have been answered to my satisfaction.

I understand that:

- The disorders detectable by newborn screening may cause life threatening conditions, serious medical conditions, physical or mental disabilities, or even death.
- Testing within 48 hours after birth is important because babies with these disorders usually look normal and these conditions may cause severe permanent health problems before any symptoms appear.
- Choosing not to have my newborn screened may result in delayed treatment if s/he has a disease or condition that can be detected by newborn screening.

I have been advised of the benefits of newborn screening and understand the potential risks to my child by not participating. Nevertheless, I refuse to have blood taken from my child for the purpose of newborn screening on the grounds that such tests conflict with my religious tenets and/or practices.

I release and hold harmless the Washington State Department of Health, the facility of birth, and the person responsible for collecting the newborn screening sample, for any injury, illness, or medical condition to my child, or even the death of my child, any of which may be caused by a disorder that is screened for under the State's newborn screening comprehensive testing panel, which screening I am hereby refusing for my child.

Due to my religious beliefs, I decline to have newborn screening tests performed on my child and I accept full responsibility for the consequences of my decision.

Child's Name: _____ Mother's Name: _____

Signed: _____ Date: _____
Parent or Guardian

SN 34800001

DOH 304001 (rev- 01-16) 01/19

If parents refuse newborn screening for religious reasons:

- Have parents read the Refusal of Testing statement on the back of the screening card
- Complete all demographic information on the front of the card AND check the box indicating "Refused"
- Parents must sign and date to indicate refusal of testing
- Mail refusal cards to the State Laboratory right away, just like a blood specimen

Please:

- Do not place stickers/tracking labels over any demographic information or the "DO NOT USE THIS AREA" section
- Do not separate the filter paper from the demographic information. The barcode number for the filter paper, demographic information section, and hearing card (if present) must match for each child
- Keep record of the unique barcode number in the child's chart and/or on a tracking log of screening specimens submitted

DOH 951-125 Feb2016

For people with disabilities, this document is available upon request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

Newborn Screening Collection Cards Instructions

Front Left

MOTHER'S INFORMATION	
LAST NAME	
FIRST NAME	
Maternal Steroids <input type="checkbox"/> (within 7 days)	Date last _____
MISCELLANEOUS INFORMATION	
BIRTH FACILITY	
Facility ID (born at): _____	
Name of Facility: _____ (For home-birth, use birth attendant ID)	
SUBMITTER ID	FOLLOW-UP CARE
Collected at (facility): _____-_____-_____ <input type="checkbox"/> Same as Birth Facility	Follow-Up Clinic ID: _____-_____-_____ <input type="checkbox"/> Same as Submitter
<input type="checkbox"/> REFUSED: Check box if refused and sign form on reverse (required)	

Complete list of ID numbers available online:
www.doh.wa.gov/NBS/IDNumberDirectories

Mother's Information

- Write mother's legal first and last name (Do not include middle names)
- Check box if the *mother* received steroids within the last 7 days
- Indicate the date when steroids were last administered to the mother

Miscellaneous Information

- Indicate anything relevant, such as: adoption, foster care, surrogacy, CPS, family history of NBS disorders, moving/transferring out of state

Birth Facility

- Write the ID# for the hospital or birth center where the infant was born
- The card's yellow flap has a list of all birth facility ID#s for your use
- If home birth, write the individual midwife ID# ("M#")

Submitter ID

- Write the ID# for the facility where the specimen was collected
- If home collection, write the individual midwife ID# ("M#")
- Or check the box if same as birth facility
- Test results will be mailed to the submitter

Follow-Up Care

- Write the ID# of the facility where the child will receive outpatient care*
- If child will remain in-house, write the hospital's ID#
- Or check the box if same as submitter
- This facility will be contacted when abnormal results require follow-up
- *No longer use individual provider ID#s

Refused

- Check box if parents refuse testing AND obtain signature on back of card

Child's Information

- Write the date AND time the child was born
- Write the date AND time the specimen was collected
 - Use 24-hour based time OR check appropriate AM/PM boxes
 - ♦ Tests are specific to the child's exact age (in hours) when the specimen was collected
- Write the child's legal name and Medical Record # (if known)
- Write the sex and birth order of the child
 - ♦ This ensures the correct child is being identified
- Write the weight of the child *at birth* in grams OR pounds/ounces
 - Do not use commas or other punctuation
- For Race/Ethnicity, check all boxes that apply (if known)

Child's Special Considerations

- Check NICU box if child is or will be in the Intensive Care Unit or Special Care Nursery
- Check HA/TPN box if the child received hyperalimentation/total parenteral nutrition, or IV supplementation including amino acids **in the last 24 hours**
- Check STEROIDS box if the child received steroids **in the last 7 days**
- Check ANTIBIOTICS box if the child received antibiotics **in the last 24 hours**
- Check TRANSFUSED box if the child received red blood cell transfusion
 - Indicate the date the child was last transfused with red blood cells

Front Right

CHILD'S INFORMATION	
Birth:	Mo Day Yr Hr : Mn am pm
Collection:	_____/_____/_____ ____:_____ <input type="checkbox"/> <input type="checkbox"/>
Name:	First Last
Med Rec #:	_____
Sex:	M <input type="checkbox"/> F <input type="checkbox"/>
Birth Order:	single <input type="checkbox"/> if multiple A <input type="checkbox"/> B <input type="checkbox"/> ____
Birthweight:	____ grams OR ____ lbs. ____ oz.
Race/Ethnicity: (Check all that apply)	
White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> NaAm <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/>	
CHILD'S SPECIAL CONSIDERATIONS	
NICU <input type="checkbox"/>	HA/TPN <input type="checkbox"/> (within 24 hours)
Steroids <input type="checkbox"/> (within 7 days)	Antibiotics <input type="checkbox"/> (within 24 hours)
Transfused (RBC) <input type="checkbox"/>	Date last ____/____/____

